EXHIBIT Q

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PREPARED FOR QUALITY ASSURANCE PURPOSES

SPECIAL INVESTIGATION FINAL REPORT

NAME: King, Joseph **C#** 243229 **DIN#** 13A3662

DIAGNOSIS: Adjustment Disorder with Mixed Anxiety and Depressed Mood (P), Alcohol Use Disorder-Mild, Cannabis Use Disorder-Mild

MENTAL HEALTH LEVEL: 1S (as of 8/4/2016)

MEDICATION: None

DOB: 6/3/1968 **Age:** 50

INCIDENT TYPE: Active Patient Suicide

LOCATION OF INCIDENT: Mid-State Correctional Facility

DATE AND TIME OF INCIDENT: Friday, November 16, 2018 at approximately 2:50 am

INCIDENT DESCRIPTION:
Per NYS DOCCS Unusual Incident Report:
Description: "On 11/16/18 at approximately 2:50 AM 4B housing unit officer heard a loud bang coming from the bathroom area. CO walked into the bathroom to find a towel over the stall and sneakers on the floor and he asked who was in the stall but got no response. CO opened the stall to find the stall empty. He then noticed legs in the adjacent stall CO opened the stall door to find inmate King 13A3662 4B-9B sitting on the floor with a shoestring around his neck and tied to the electrical conduit on the ceiling. CO broke the shoestring and laid inmate King on the bathroom floor, he then removed the remaining garrote from inmate King's neck. CO called a medical response via PAS radio at approximately 2:51 AM. Sgt was notified to respond to the area."

Action Taken: "CO immediately started CPR and 4 BLDG rover CO arrived with the AED 480-02 and first aid kit. The AED was applied by CO at approximately 2:52 AM and no shock advised. CO's continued CPR while waiting for medical to respond. CO arrived at approximately 2:53 AM. RN arrived at approximately 2:55 AM and assessed the inmate as appearing cyanotic. Red mark around neck with no bleeding, no pulse detected, no respirations, no chest movement, no reflexes, pupils non-reactive, did not respond to noxious stimuli or verbal commands. Inmate was given oxygen, Narcan twice with no response. The ambulance arrived at approximately 3:25 AM. The Ambulance left the facility at approximately 3:40 AM. Inmate King was transported to St. Elizabeth's Hospital by AMCARE ambulance paramedics where he was pronounced dead by Dr. Vanessa Brown at 4:20 AM. The body was taken by Scott Beach Oneida County medical examiner…Suicide Note: 'Amy, I Love you! I guess I just have to let you do what you want. I just hope I can talk to you every day and you still come to visit me until I come home. I pray there is still hope for our relationship when I return. This is really going to be very, very hard for me to accept, because I need your help to get through this. I need you in my life and always will. I will never forgive myself for this. I am such a fool. I just pray to God there is still hope for us. I've been listening to the radio and so many songs make me think of you like I wish I had Jessies [sic]girl by Rick Springfeild [sic] and it just kills me that [sic] why I don't like to listen to the radio. Your always on my mind by Willie Nelson. Just keeps going through my mind everyday. I just cant [sic]

handle this. I just got off the phone with you. And you got so aggravated with me. I really think you want to end our relationship. I don't want to hurt you or the kids but I don't really think I'll make it through the night. I feel its time [sic] so say goodbye. I hope your happy to do what you want now that I'm out of your life. Because I know you really don't want me anymore. And I can't live with myself. I'm sorry I don't want to hurt you or the kids but I can't live without you. I am so sad, unhappy, and you are breaking my heart. I just can't do this anymore. I'm sorry. I love you! Love your Husband Joe Good-bye my beautiful. I love you! And I [sic] sorry. Tell Meghan and Joseph I love them and I'm sorry. Please Forgive me! You have broken my heart and I need to kill this pain.'"

INVESTIGATOR: Jennette Brady, CBO Risk Management Specialist

I. THE INCIDENT

A. The date and time the incident allegedly occurred, if known:
Friday, November 16, 2018 at approximately 2:50 am.

B. The date the incident was reported:
Friday, November 16, 2018 at approximately 7:41 am

C. The name of the person or persons reporting the incident:
Debra Betti, Acting Unit Chief

D. Date facility management staff notified of the incident:
Friday, November 16, 2018 at approximately 8:28 am

E. Date and time the investigator was assigned the case:
Friday, November 16, 2018 at approximately 7:41 am

F. Date and time the incident reported externally:
Friday, November 16, 2018 at approximately 8:28 am

G. Date and time "target(s)" separated from alleged victim:
N/A

II. INVESTIGATIVE PROCEDURE

A. GENERAL INFORMATION

1. The dates and times the investigator visited the site of the incident:
January 8, 2019 at 11:00 am to 1:00 pm

2. The person(s) with whom the investigator spoke at the site (Not witness interviews):
Jami Palladino, Social Worker II, Carrie Citrin, Psychiatric Nurse Practitioner, Karen Thomas, Psychiatrist II

B. COLLECTING PHYSICAL AND DEMONSTRATIVE EVIDENCE

1. The manner in which the scene of the incident, if any, was secured. CNYPC outpatient Satellite Units are located at various prisons in New York State:
Physical evidence related to the incident is collected and reported on by the Department of Corrections and Community Supervision (DOCCS).

2. A list of each piece of physical evidence collected: Per DOCCS

3. **The manner in which the physical evidence was collected and logged:** Per DOCCS

4. **The manner in which the physical evidence was kept after collection in order to maintain the chain of custody:** Per DOCCS

5. **A list of any pictures that were taken:** Per DOCCS

6. **A list of any other demonstrative evidence available to the investigator-i.e. diagrams, maps, floor plans, x-rays:** Per DOCCS

7. **Results of physical examinations:**
As per DOCCS Ambulatory Health Record Progress Note completed on 11/16/2018: "At approximately 2:50 AM a medical emergency was called for housing unit 4-B. 2 minutes later this writer was notified to call for ambulance. A call made to Kunkle ambulance. This writer tried to call MS voice mail answered. This writer was then transported to housing unit 4B with rounds van. Upon arrival to unit inmate was noted to be on the unit bathroom floor with AE attached and on. CPR was already in progress by 2 officers. This writer began to assess the inmate. Inmate appeared cyanotic, red mark around neck, no bleeding, no pulse detected, no resp, no reflexes, pupils non-reactive, not responding to noxious stimuli or verbal commands. At this time, I advised officers to continue CPR, oxygen started/applied, Narcan given per DOCCS protocol X 2 with no response. VS: 97.4, pulses 0, resp 0, O2 sat 0/undetected, blood sugar 208, BP undetected. AED advised no shock and advised to continue CPR upon connecting fluid line. AM-Care ambulance staff arrived and took over inmate's care, AM Care staff applied neck brace, inmate was then transported off housing unit via AM-Care staff/ambulance with CPR in progress. Inmate left via ambulance from unit at approximately 3:35 AM CPR in progress. Upon returning back to bldg. 114 calls made to MD, orders were obtained from MD. OK to give Narcan per protocol. Ok to start Periph IV. OK to use 0.9% NS. Ok to check finger stick. Send inmate to nearest hospital for higher level of care via ambulance. Read back and confirmed by MD. Set to St. Elizabeth via Ambulance. At approx. 4:45 AM received call from Lt. inmate pronounced deceased at 4:20 AM."

C. TESTIMONIAL EVIDENCE

1. **The way in which the investigator determined whom to interview**: It is standard practice to interview the patient's Primary Therapist, Nursing staff and the Psychiatrists who were direct caregivers to the patient involved in the incident; therefore, those staff were identified for interview in this case.

2. **A list of all persons interviewed/who provided statements in chronological order, including date and time:**

NAME	TITLE/RELATIONSHIP	DATE/TIME
Jami Palladino	Social Worker II	January 8, 2019
Carrie Citrin	Psychiatric Nurse Practitioner	January 15, 2019
Karen Thomas	Psychiatrist II	February 27, 2019

3. **The person or persons, if any identified as the target or targets of the case:**

N/A

4. **The way in which the investigator afforded the target or other witnesses any right to representation if such rights exist by contract or other regulation or by law:** If at any time an interrogation of any employee is done, that employee will be offered the right to representation according to procedures established pursuant to the labor agreements. Interviews conducted for the purpose of this Special Investigation report were not interrogatory.

III. DOCUMENTARY EVIDENCE:

A. Legal and Criminal History:

Mr. King was transferred to the NYS Department of Corrections and Community Supervision (DOCCS) on 5/15/2013 to serve his first NYS sentence after being convicted of Arson 3rd degree. He was sentenced to the term of 4-to-12 years of incarceration. Per DOCCS record, Mr. King's maximum expiration release date was 5/24/2024 and his conditional release date was 5/24/2020.

According to the Pre-Sentence Investigation (PSI) report from Essex County dated 8/5/2013, Mr. King's criminal record began in 1989. It consisted of four contacts with the criminal justice system, resulting in three drunk driving arrests and one misdemeanor arrest (Criminal Mischief 4th-two counts, Driving While Intoxicated, and two Driving While Ability Impaired). Mr. King was never under the supervision of probation and did not have an out of state legal history.

While incarcerated for the instant offense, Mr. King accrued two Tier 2 misbehavior reports on 10/13/2016 for disorderly conduct, 8/27/2018 for direct order, and unauthorized phone use. He also accrued three Tier 3 misbehavior reports on 1/11/2017 unauthorized medication and smuggling, 1/17/2017 and 5/10/2018 for drug use.

B. Substance Abuse History:

According to the PSI dated 8/5/2013, Mr. King began using alcohol at the age of eight years old, when he accompanied his parents to parties/bars. Mr. King started drinking with a friend in middle school, and by high school he was drinking three times a week; his drinking progressed to daily use to the point of intoxication from age 18 to 25. Mr. King decreased his alcohol use when he began dating his wife and reported further decrease in his alcohol use after the birth of their daughter.

Mr. King first used marijuana when in 4th grade and continued to use marijuana daily until he was arrested. Other substance use reported was LSD (10-15 times) while in high school and cocaine a couple of times at the age of 18.

According to the Core History updated by Mid-State OMH staff on 6/16/2017, Mr. King had a "history of using Suboxone on and off over the last year."

According to DOCCS data, Mr. King received a Tier 3 misbehavior report on 5/10/2018 for drug use. Available clinical records for the six months prior to Mr. King's death noted substance use concerns. During the 6/25/2018, 7/23/2018, 8/27/2018, and 9/27/2018 therapeutic sessions, Mr. King made note to his therapist and prescriber that he had been sporadically using Suboxone during this incarceration.

C. Physical Health History:

A review of Mr. King's record indicated that he previously reported being in good physical health with no medical concerns. He reported no known drug allergies. Further review of DOCCS medical records (FPMS) indicated that he was diagnosed with Hypertriglyceridemia and back pain without radiating symptoms while he was at Downstate Correctional Facility Reception Center on 8/20/2013.

Per the PSI dated 8/5/2013, Mr. King was involved in head injury accidents on three occasions. At the age of 19, Mr. King had an accident on a 4-Wheeler while intoxicated, lost consciousness for three days and later experienced coordination issues on the right side of his body for one year. At the age of 22, while intoxicated and crossing a street, he was struck in the forehead by a plow attached to a pick-up truck and lost consciousness. At the age of 39, he had another accident on a 4-Wheeler while intoxicated, and lost consciousness for eight hours. It was noted that Mr. King reported experiencing headaches, memory issues, increased depression/anxiety and reduced tolerance for alcohol since the accidents. It was also reported that Mr. King did not receive any testing or evaluations to determine the extent of the head injuries.

D. Family History/Involvement:
At the time of his admission to mental health services at Downstate Correctional Facility Reception on 10/2/2013, as well as during subsequent interviews, Mr. King reported that he was raised by his married biological parents. Mr. King was the youngest of two brothers and four sisters. Mr. King's father passed away in 2006.

Mr. King was married and had two children. Records indicate Mr. King had a supportive relationship with his family.

E. Religious/Spiritual Beliefs:
Per the initial Core History completed on 10/2/2013, Mr. King practiced the Catholic faith.

F. Suicide Attempt History/CSRA:
Mr. King's record is remarkable for one suicide attempt while incarcerated. On 7/11/2016, Mr. King attempted suicide via hanging. At that time, it was reported to OMH staff that Mr. King had been using Suboxone for approximately four to five months and his supply was no longer available. He was not able to manage the withdrawal symptoms he was experiencing and viewed suicide as a means to solve his problem in that moment.

Per the PSI, Mr. King presented at the CVPC ER in February of 2009 due to experiencing symptoms of depression and anxiety and reporting suicidal ideations "thoughts to shoot himself."

CSRA dated 8/27/2018 (completed during the inpatient course of treatment at CNYPC):

Biological Chronic/Acute Risk Factors – History of psychiatric illness; Substance abuse/dependence history; Chronic pain
Protective Factors – (Nothing checked)

Psychological Chronic/Acute Risk Factors – Prior suicide attempts (1); Prior suicide ideation/threats; History of non-suicidal self-injury; Prior psychiatric treatment; Family history of mental illness/suicide; Borderline/Antisocial personality traits; Impulsive behavior; Fear/anxiety; Guilt/rumination; Mood instability
Protective Factors – (Nothing checked)

Socio-Cultural Chronic/Acute Risk Factors – Convicted of a violent crime; Recent rejection or loss; First prison term; Long or life sentence; Tickets/SHU/KL/disciplinary sanctions; gang-related threats/fears
Protective Factors – Cultural/religious beliefs that discourage suicide; Supportive family and/or friends; Children at home

Environmental Chronic/Acute Risk Factors – (Nothing checked)
Protective Factors – (Nothing checked)

Demographic Chronic/Acute Risk Factors – Male (for completions); Caucasian/Native American
Protective Factors – (Nothing checked)

1) **If a patient/resident has previous suicide attempts, please describe the nature of and triggers to these events:** "On 7/11/16 Mr. King attempted to hang up while he was supposed to be at program. He went to the 3rd floor of the building where there is no employees or inmates present or expected to be in that arear [sic]. He reported he tied a black shoelace to the security screen and around his neck. he [sic] reported the shoelace broke and fell, landing on his nose and forehead. he [sic] reported that he went to his program, completed his work module, then returned to his unit on go-back. He reported that he told CO about the incident. He reports that he was examined by medical and the doctor deemed it as a suicide attempt. Pt presented with clear ligature marks, swollen nose, and a raised nodule to the right side of his forehead. he was referred to St. Luke's hospital for further evaluation prior to returning to midstate [sic] OBS.
Mr. King reported to staff that he was withdrawing from Suboxone at thetime [sic] of the suicide attempt. Substance use is an identifiable trigger for increased suicide risk."

2) In your clinical opinion, is the patient/resident experiencing current suicidal ideation/intent? (Please describe and include subjective and objective indications of suicide risk and intent): "No"

3) Please describe the patient/resident's current risk for suicide, incorporating: a. Prominent risk factors, b. Prominent protective factors, c. Suicidal ideation/attempts, d. Identifiable triggers to future suicidal behavior (e.g., loss of family contact, anniversaries, etc.):
"A. history of psychiatric illness, substance abuse/history, chronic pain, prior suicide attempt, prior suicidal ideation/threat, history of nonsuicidal [sic] self-injury, prior psychiatric treatment, family history of MI/SI, borderline/antisocial personality traits, impulsive behaviors, anxiety, guilt/rumination, mood instability, convicted of a violent crime, significant loss of his mother in June [sic] 2018, first prison term, ling sentence, tickets/SHU/KL/ disciplinary sanctions, possible gang related threats/fears, male, Caucasian.
B. Cultural religious beliefs that discourage suicide, supportive family and or friends, children at home.
C. See above
D. Overwhelmed with prison sentence withdrawal form substances, loss of family contact."

4) Recommendation/Plan:
"Mr. King is currently offered individual therapy once per month and psychiatric evaluations every 90 days, or as clinically indicated. Patient will participate in monthly individual therapy to develop coping strategies and reduce risk factors for suicide as possible. He will

be encouraged to comply with all treatment recommendations and to notify Mental Health and/or facility staff promptly if experiencing suicidal ideation, intent, or plan."

G. Mental Health History:

According to the Core History dated 6/16/2017, Mr. King denied any inpatient hospitalizations. He reported that he engaged in self-injurious (cutting) behaviors during his adolescence for stress release.

Post-mortem information was received from DOCCS that provided further detail related to his community treatment history. Mr. King was previously referred for outpatient treatment at Ticonderoga Health Center related to his past head injuries as well as symptoms of anxiety, depression, and sleep issues for which he was prescribed Citalopram, Hydroxine, and Trazodone. In February of 2009 Mr. King was treated at the CVPC ER due to experiencing symptoms of depression and anxiety and reportedly had thoughts to 'shoot himself'. He was diagnosed with Depression and Alcohol Abuse at that time. He was then referred to Essex County Mental Health for further outpatient treatment services. Mr. King continued to receive services, including medication, through Essex County Mental Health while in the county jail for 14 months. In July of 2013 he was diagnosed with: Anxiety Disorder NOS, Cannabis Dependence, Alcohol Dependence and a rule -out of Dysthymia.

During incarceration, Mr. King required two admissions to RCTP. His first admission was from 8/15/2013 to 8/16/2013 (for mental health assessment due to Mr. King being a new transfer) and his second admission was from 7/11/2016 to 8/4/2016 (after a suicide attempt).

H. Per Central New York Psychiatric Center Outpatient Medical Record Chronological Record Form [410 Med CNYPC], review of UCR and FPMS

1)Timeline

- **8/15/2013:** Entered DOCCS via Clinton Reception to serve first NYS sentence for instant offense; MHSL 3 and was placed in Clinton RCTP-Dorm
- **8/16/2013:** Transferred from Clinton CF to Downstate CF
- **10/17/2013:** Transferred from Downstate to Franklin CF
- **1/8/2015:** MHSL changed from 3 to 2 (due to placement on multiple psychiatric medications).
- **2/6/2015:** Transferred from Franklin CF to Mid-State CF
- **7/11/2016:** Suicide Attempt (hanging)
- **7/11/2016:** Placed in Mid-State CF's Infirmary on a 1:1 status (RCTP)
- **7/12/2016:** Moved from Mid-State CF's Infirmary to the RCTP observation cells (OBS)
- **7/14/2016:** Moved from Mid-State CF's RCTP OBS to the RCTP Dorm
- **7/16/2016:** Moved from Mid-State CF's RCTP dorm to the SHU on 1:1 status
- **7/18/2016:** Moved from Mid-State CF's SHU back to the RCTP OBS
- **7/19/2016:** Moved from the Mid-State CF's RCTP OBS to the RCTP Dorm
- **8/4/2016:** MHSL changed from a 2 to a 1S (due to 7/11/2016 suicide attempt)
- **8/4/2016:** Program change to Mid-State CF GP
- **11/16/2018:** Mr. King committed suicide in his GP dorm bathroom at approximately 2:50 am. He was pronounced deceased at 4:20 am.

2) Chronological Progress Notes (6 months prior to death):

- **Monitored at Mid-State Correctional Facility**

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- **5/14/2018 Primary Therapist Progress Note**
  - Focus of Session: "Pt was seen by this writer for his monthly callout in conjunction with the VTC doctor and to follow up on how he was coping with the loss of his mother. He arrived early, and was observed sitting calmly in waiting room with several peers when this writer approaches the reception area. Mr. King described his moods as 'depressed and anxious.' He continues to endorse being compliant with medication. 'I need something to calm me down. I'm not hungry, I'm not eating much, and I'm not sleeping'. Writer pointed out that he recently experienced a significant loss, and that he may experience some physical symptoms as he is working to cope with this. 'I was feeling like this before my mother died. People tell me not to tell you because I will make it worse for myself.' Writer pointed out that he would be expected to address these reported symptoms in this setting, and that it wouldn't necessarily mean he would be placed in OBS unless he was threatening to harm himself, or experiencing psychotic decomp. Pt denied experiencing any psychotic symptoms or wanting to harm himself. Mr. King shared with writer that he was in MICA ASAT, and is working on the Lawns and Grounds program. Writer pointed out that it would keep him more active, and that he has already completed the regular ASAT so he knows the foundation. 'I know. This sucks that I have to go back to ASAT.' Writer pointed out that this is a repercussion for his prior substance use. 'I'm just tired of being in jail.' Writer asked how he was coping with his mother's passing. Writer offered therapeutic worksheets on grief/bereavement, but pt refused. Mr. King continues to maintain contact with his wife, children, and sister. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of emergency."
  - Progress toward treatment plan goal(s)/objective(s):
    "A. Patient attended and participated in session. No overt symptoms of depression or anxiety was observed during session although he reported both. His mother recently passes away. He denies any suicidal ideations, plan, or intent.
    B. Copes by reading, doing crossword puzzles, and programming in MICAASAT and Lawns and grounds.
    C. Pt is compliant with medication, but was focused on 'more medication for my nerves.'"
  - Medication Compliance: "Yes"
  - Mental Status/Clinical Observation:
    "Appearance: Pt presented with adequate grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. No psychomotor agitation/retardation was observed during session. Adequate attention and concentration exhibited. Pt maintained eye contact.
    Speech: Speech was at normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.
    Thought Process: Clear, logical, organized, and goal directed
    Mood: Mood 'depressed and anxious'
    Affect: Affect appeared constricted
    Insight/Judgment: Insight and judgment appear functional for this environment.
    Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional

content expressed.
Other Observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported 'no sleep' and that he 'has no appetite. I'm not hungry.' However, he didn't appear tired or underweight."

- Suicide Risk Assessment:
  A) Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA? "No"
  B) Describe suicide warning signs/triggers which are present or indicate none present: "There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. Pt reported anxiety, mood change. His mother passed away, but he reported experiencing issues before. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts."
  If present, describe the effect on patient's functioning & plan to address: "N/A. He does not present with evidence of or symptoms suggestive of suicidal ideation at this time."
- Follow-Up/Plan: "Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled."

- **5/14/2018 Psychiatric Progress Note**
  - MED 15 Diagnoses: Mental Health: "Adjustment Disorder with Mixed Anxiety and Depressed Mood"
    Physical Health: "No acute issues"
  - Chief Complaint and Current Issues: "Pt is a 49 y/o man on his 1st NYS BID, CR 5/2020 with reported history of outpt MH treatment for depression, self-harm and substance use. Pt lost his mother 1 week ago. Today he reports 'needing something to calm me down.' He reports feeling depressed, anxious, sleeping poorly. We discussed that some of his symptoms are appropriate with his recent loss. Pt is adamant he was struggling prior to the loss of his mother and is requesting a med change."
  - Changes in Medical Status: "No reported changes"
  - Mental Status Examination and Changes: "Caucasian man, thin, dressed appropriately in prison attire. Fair eye contact, polite, calm, cooperative, [no] psychomotor disturbance. Speech-normal tone and rate. Mood-not good. Affect: Anxious. Linear thought process. Denies SI/HI. Denies AH/VH."
  - Assessment of Suicide Risk: "+ Anxiety, recent loss of mother. Pt denied current SI, has support from his sister and is goal directed for treatment"
  - Assessment/Current Diagnostic Impression/Plan: "Will continue to titrate celexa [sic] and vistril [sic] to address mood and anxiety. Continue therapy."
  - Psychiatric Medications: "Celexa 40 mg popm- depression; Vistaril 100mg popm-anxiety"
  - Medical Medications: "None."
  - Medication Education Provided (check when provided): (Not checked)
  - Additional Information: (blank)
  - Follow up: "4-6 weeks and prn"
- **6/25/2018 Primary Therapist Progress Note**
  - Focus of Session: "Pt was seen by this writer for his monthly callout in conjunction with the VTC doctor and to follow up on how he was coping with the loss of his mother. He arrived early, and was observed standing in the waiting room with several peers when this writer approaches the

reception area. Mr. King described his moods as 'still depressed.' He endorsed being compliant with medication. However, he continues to report that they are ineffective in addressing his symptoms. 'I'm still depressed man. I don't feel like doing anything. I have no motivation to do anything.' Pt adamantly denied experiencing thoughts of self-harm or psychotic symptoms. It can be noted that pt was recently in the hospital, and unresponsive. When asked about how he has been doing, he replied 'I was low on sodium and dehydrated.' Upon further discussion, pt acknowledged that he has been using suboxone, and has obtained disciplinary tickets for drug use. 'I haven't used in a really long time; like two weeks.' When asked about how he has been coping with his reported anxiety, pt stated that 'what [sic] is that? I don't understand what you're asking. I don't feel anxious at all.' Pt continues to endorse maintaining contact with his wife, children, and siblings. Writer engaged pt in a discussion about how he has been coping with the passing of his mother. Writer asked if this was a trigger for thoughts of suicide or harming himself. 'No way, I'll never do that again.' It was decided by the prescriber to taper off medication to see how he functions without it, and to start over to figure out what may be helpful. Pt will be seen in one month by prescriber to follow up on how he was doing, and whether medication is clinically indicated. Writer pointed out that concern from MH in relation to using drugs and taking psychotropic medication and what can happen along with the medication not actually addressing what it needs to address because of the substance use. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to t reach out to MH in case of an emergency."

- Progress toward treatment plan goal(s)/objective(s):
  "A. Patient attended and participated in session. No overt symptoms of depression or anxiety was observed during session although he reported 'depression.' Pt recently obtained tickets for drug use, and he acknowledged using suboxone. He denies any suicidal ideations, plan, or intent.
  B. Copes by reading, doing crossword puzzles, and programming in MICA ASAT and Lawns and grounds.
  C. Pt is compliant with medication, but continues to report that they are ineffective in addressing his reported symptoms."
- Medication Compliance: "Yes"
- Mental Status/Clinical Observation:
  "Appearance: Pt presented with adequate grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. Some psychomotor agitation was observed during session. Pt would continually move his legs up and down. Adequate attention and concentration exhibited. Pt maintained eye contact.
  Speech: Speech was at normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.
  Thought Process: Clear, logical, organized, and goal directed
  Mood: Mood 'still depressed'
  Affect: Affect appeared constricted
  Insight/Judgment: Insight and judgment appear functional for this environment.
  Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed.

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Other Observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported issues with sleep and motivation. No issues reported in relation to his appetite. He didn't appear tired or underweight."

- Suicide Risk Assessment:
  A) Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA? "No"
  B) Describe suicide warning signs/triggers which are present or indicate none present: "There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. Pt reported anxiety, mood change. His mother passed away, but he reported experiencing issues before. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts."
  If present, describe the effect on patient's functioning & plan to address: "He does not present not present with evidence of or symptoms suggestive of suicidal ideation at this time."
- Follow-Up/Plan: "Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled."

- **6/25/2018 Psychiatric Progress Note**
  - MED 15 Diagnoses: Mental Health: "Adjustment Disorder with Mixed Anxiety and Depressed Mood"
    Physical Health: "No acute issues"
  - Chief Complaint and Current Issues: "Pt reports feeling the same with the recent med changes. Pt received a drug ticket after the loss of his mother. He admits to using suboxone a few times since last session 5/14/18. Pt c/o feeling unmotivated, tired, and depressed. He rates depression 7/10 and states he's been feeling this way for months. Pt reports last being clean from suboxone for 6 months in 2017."
  - Changes in Medical Status: "No reported changes"
  - Mental Status Examination and Changes: "Caucasian man, dressed appropriately in prison attire. Fair eye contact, no psychomotor disturbance, calm, cooperative. Speech-normal tone and rate. Mood- 'not good' Affect: Constricted, Goal directed thought process. Denies SI/HI. Denies AH/VH."
  - Assessment of Suicide Risk: "No warning signs present"
  - Assessment/Current Diagnostic Impression/Plan: "Discussed current symptoms and suboxone use. Will taper and D/C Celexa and Vistaril. Pt doesn't find effective. Discussed initiating Am med trial with Prozac- pt declines at this time. Continue therapy."
  - Psychiatric Medications: "Celexa taper and D/C; Vistaril taper and D/C"
  - Medical Medications: "None."
  - Medication Education Provided (check when provided): (Not checked)
  - Additional Information: (blank)
  - Follow up: "2 months and prn"
- **7/23/2018 Psychiatric Progress Note**
  - MED 15 Diagnoses: Mental Health: "Adjustment Disorder with Mixed Anxiety and Depressed Mood"
    Physical Health: "No acute issues"
  - Chief Complaint and Current Issues: "Pt reports feeling worse. He states he has a lot of anxiety and reports pacing during the day and 'panic attacks'. 'Panic attacks' consist of feeling warm, numb and cause him to get up when

trying to sleep. Pt reports feeling more depressed, but denies SI. He states he's been driving his wife crazy and asked her to call MH to explain he was not doing well. Sleep has been more difficult. Pt reports increase difficulty concentrating and is unable to read or do puzzles. He continues to have support from his wife and kids. Pt requests to restart trazodone and reports doing well on it previously."

- Changes in Medical Status: "No reported changes"
- Mental Status Examination and Changes: "Caucasian man, appropriately dressed, fair eye contact, calm, cooperative, pannormal [sic] movements, speech-normal tone and rate. Mood- 'Depressed' Affect: Dysphoric. Linear thought process. Denies SI/HI. Denies AH/VH."
- Assessment of Suicide Risk: "No warning signs present"
- Assessment/Current Diagnostic Impression/Plan: "Will initiate med trial with zoloft [sic] and trazodone [sic] to address anxiety and depression. Continue therapy."
- Psychiatric Medications: "Zoloft 50 mg po pm; Trazodone 50 mg po pm for depression and anxiety"
- Medical Medications: "None."
- Medication Education Provided (check when provided): (checked)
- Additional Information: (blank)
- Follow up: "4-6 weeks and prn"

- **7/23/2018 Primary Therapist Progress Note**
  - Focus of Session: "Pt was seen by this writer for his monthly callout in conjunction with the VTC doctor and to follow up on the letter her wrote. He arrived early, and was observed standing in the waiting room with several peers when this writer approaches the reception area. Mr. King described his moods as 'I feel terrible. I have a lot of anxiety.' He is not currently prescribed medication due to concerns of the prescriber from previous session. H stated that he has been experiencing 'panic attacks, pacing, a lot of anxiety. My heart is racing, I can't breathe, I get hot, I can't sit down and I can't sleep. I have to keep moving.' Pt denied experiencing any psychotic symptoms or wanting to harm himself. 'I need help or something. I'm not sleeping good.' Sleep hygiene was discussed. He was encouraged to refrain from sleeping during the day, and monitoring his caffeine intake. Write reminded him that medication isn't prescribed for sleep, and noted that he has been continually encouraged to participate in therapy to learn new coping skills. Mr. King endorsed coping with his incarnation be going to the yard, working as a porter, and pacing. He continues to endorse contact with his wife, children, and his siblings who are supportive of him. When he was informed that he would be prescribed Zoloft, and that it could take a few weeks to get the full effect, pt stated 'aw man, are you kidding me?' It was also noted that pt has been using substances in addition to taking medication and that he may be experiencing withdrawal as well. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency."
  - Progress toward treatment plan goal(s)/objective(s):
    "A. Patient attended and participated in session. Pt reported that he was coping with 'bad anxiety'. He was observed pacing in waiting area. Some psychomotor agitation was noted. He denies any suicidal ideations, plan, or intent."

B. Copes by going to the yard, working as a porter, and pacing. He denied and [sic]
C. Pt is not currently prescribed any medication, but is requesting to restart new medication."

- Medication Compliance: "Yes"
- Mental Status/Clinical Observation:
"Appearance: Pt presented with good grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. Some psychomotor agitation was observed during session. Pt could not stop moving his legs. Adequate attention and concentration exhibited. Pt maintained eye contact.
Speech: Speech was at normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.
Thought Process: Clear, logical, organized, and goal directed
Mood: Mood 'I feel terrible. I have a lot of anxiety.
Affect: Affect appeared constricted
Insight/Judgment: Insight and judgment appear functional for this environment.
Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed.
Other Observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported 'poor sleep' and that he 'has no appetite. I'm not hungry'. However, he didn't appear tired or underweight."
- Suicide Risk Assessment:
A) Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA? "No new risk/protective factors"
B) Describe suicide warning signs/triggers which are present or indicate none present: "There is no evidence of any warning signs of acute suicide risk in patient's behavior or affect. Pt reported anxiety, mood change. His mother passed away, but he reported experiencing issues before. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts."
If present, describe the effect on patient's functioning & plan to address: "He does not present not present with evidence of or symptoms suggestive of suicidal ideation at this time."
- Follow-Up/Plan: "Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled."

- **8/27/2018 Primary Therapist Progress Note**
  - Focus of Session: "Pt was seen by this writer for his monthly callout in conjunction with the VTC doctor. He arrived early, and was observed standing in the waiting room with several peers when writer approaches the reception area. Mr. King described his mood as 'edgy, nervous.' He acknowledged being compliant with medication, but stated that it was not effectively addressing his symptoms long term. Pt was informed that he would not be prescribed any new medication if he wasn't actively trying to increase coping skills other than medication. He denied experiencing any psychotic symptoms or wanting to harm himself. Pt is continuing to report experiencing no energy or motivation. He stated 'I lay I n bed all day, and I can't sleep. I only get like three to four hours of sleep a night. I'm tired of

doing the same thing every day. I can't take this anymore.' Writer asked pt about this last use of suboxone. 'A long time, like three weeks ago'. Writer pointed out that he has no idea if the symptoms he is experiencing are a result of his active use of drugs, interaction with medication, or the result of prior use, and he is withdrawing. Writer reminded him that he is responsible for his decisions, and for the repercussions of using substances. He was reminded that he can obtain SHU time for choosing to use substances. 'I tell you right now, if I go to the box, I will be suicidal.' However, he denied wanting to harm himself. 'I don't like being by myself'. Writer pointed out that maybe because the actual issue lays within himself, not prison. It was noted that his medication may be discontinued if he is going to actively use substances because they can't effectively treat him if he is using substances on top of that. 'that's not fair. Other people use drugs and get to have their MH medication; why can't I?' Writer noted that everyone's circumstances are different, and that doesn't necessarily be true. Also, it can be noted that what doesn't affect one person may affect someone totally different. Writer asked if his wife is aware of his substance use. He stated that she was, and she wasn't happy with him. 'it started because my visits were starting to go bad'. No further explanation was provided. He was encouraged to actively seek treatment like AA/NA meetings, Pt told staff that he was removed from ASAT for substance use. Writer noted that MH can't help him if he isn't willing to help himself, and that pt doesn't appear motivated for change. She informed staff and pt that in the last year he has eliminated several coping skills in place of using substance. He quit his paint crew job, stopped attending AA/NA, stopped going to religious services, and reports 'nothing helps' but isn't willing to complete worksheets, attend coping skills group, or actively participate in treatment. Pt was encouraged to do something like go outside to the yard for exercise, attend AA/NA, do worksheets otherwise medication will be discontinued in the future if he isn't participating in his MH treatment. Mr. King requested an increase of Trazodone for sleep. It was reiterated that medication would not be changed until he attempted to use alternative coping skills. Writer reiterated that medication wasn't prescribed for sleep. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency."

- Progress toward treatment plan goal(s)/objective(s):
  "A. Patient attended and participated in session. Pt continues to report 'edgy, anxiety, depression'. It can be noted that pt is actively using substances. He denies any suicidal ideations, plan, or intent.
  B. Copes by lying in bed all day.
  C. Pt is compliant with medication, but reporting they are ineffective."
- Medication Compliance: "Yes"
- Mental Status/Clinical Observation:
  "Appearance: Pt presented with good grooming and hygiene. He was neatly dressed in state issued clothing that was appropriate for the weather. Some psychomotor agitation was observed during session. Pt could not stop moving his legs. Adequate attention and concentration exhibited. Pt maintained eye contact.
  Speech: Speech was at normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.
  Thought Process: Clear, logical, organized, and goal directed

Mood: Mood 'I'm edgy, anxious, depressed.'
Affect: Affect appeared constricted and irritable.
Insight/Judgment: Insight and judgment appear functional for this environment.
Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed.
Other Observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt reported 'poor sleep' but improved appetite. However, he didn't appear tired or underweight."

- Suicide Risk Assessment:
  A) Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA? "Yes" "Updated as per policy."
  B) Describe suicide warning signs/triggers which are present or indicate none present: "Pt reported anxiety, mood change, and admitted to substance use. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts."
  If present, describe the effect on patient's functioning & plan to address: "Pt was offered worksheets, but pt continues to request additional medications, and refuse worksheets."
- Follow-Up/Plan: "Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled."

- **8/27/2018 Psychiatric Progress Note**
  - MED 15 Diagnoses: Mental Health: "Adjustment Disorder with Mixed Anxiety and Depressed Mood"
    Physical Health: "No acute issues"
  - Chief Complaint and Current Issues: "Pt seen for his follow-up. He explains he's not doing well and feels edgy. Pt admits to Suboxone use 2-3 x since last appointment. States it helps with his anxiety but wants plans to stop. He reports feeling depressed, edgy, and unmotivated. Pt denies SI but reports anhedonia and mostly lying in his bed during the day. Pt reports sleeping 3-4 hours at a time with trazodone [sic]. Sleep hygiene discussed. Continues to have support from his wife and kids."
  - Changes in Medical Status: "No reported changes"
  - Mental Status Examination and Changes: "Caucasian man, appropriately dressed, intermittent eye contact, no psychomotor disturbance, speech-normal tone and rate. Mood- 'Not good' Affect: Constricted. Linear thought process. Denies SI/HI. Denies AH/VH."
  - Assessment of Suicide Risk: "No warning signs present"
  - Assessment/Current Diagnostic Impression/Plan: "Pt counselled on harms of substance use. He was encouraged to return to AA/NA. Pt will do anxiety packet from therapist to help learn relaxation techniques. Pt agreeable with plan and understands meds will be stopped if drug use continues"
  - Psychiatric Medications: "Zoloft 50 mg po pm; Trazodone 50 mg po pm for depression and anxiety"
  - Medical Medications: "None."
  - Medication Education Provided (check when provided): (Not checked)
  - Additional Information: (blank)
  - Follow up: "2 months and prn"
- **9/27/2018 Primary Therapist Progress Note**

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- Focus of Session: "Pt was seen by this writer for his monthly callout. He arrived early, and was observed sitting patiently in the waiting room with several peers when writer approaches the reception area. Mr. King described his mood as 'I still feel terrible.' Pt continues to report being compliant with medication, but stated 'they don't work'. He informed writer that he continues to experience 'crazy anxiety, depression, and is not motivated to do anything. I don't know what to do. What medications can I get? I was told by some people that the Prozac is good. I sure wish she would have put me on it so I can feel better.' Writer asked about skills he has been using to cope with his reported symptoms. Mr. King denied reviewing any worksheets, using relaxation techniques or attending AA/NA meeting to help address his substance abuse issues. Writer reminded him that the prescriber was unwilling to make any medication changes if he wasn't complying with treatment recommendations. Mr. King identified playing solitary, and doing crosswords as his main source of coping skills. 'I was kicked out of ASAT, because of that stupid ticket for a dirty.' Mr. King expressed concern about his upcoming parole board, and his disciplinary record in the last year. Writer pointed out that he is aware that there are consequences for good and bad choices one may make. 'I don't know what I'm going to do if I have to stay incarcerated for another two years. I'm so bored. This isn't fair. I got too much time. I want to go home.' Writer will make treatment team aware of concerns prior to his parole board 1/2019. Mr. King endorsed maintain contact with his wife, children, sisters, and his brothers who are supportive of him. He noted that his son dropped out of college and is trying to find work. 'He plays a mean guitar. he has a band.' Writer informed pt that he was just seen by a prescriber, but due to staff changes that he would be meeting with ta different prescriber at next visit. He was encouraged to drop a slip explaining his concerns about his medications. Writer reiterated concern from MH in relation to using drugs and taking psychotropic medications and what can happen along with the medication not actually addressing what it needs to address because of the substance use. 'I haven't used [sic] No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency."
- Progress toward treatment plan goal(s)/objective(s):
  "A. Patient attended and participated in session. He continues to report 'extreme anxiety and depression, lack of motivation'. No overt symptoms of depression or anxiety was observed during session. Pt recently obtained tickets for unauthorized phone use. No DOCCS referrals received, contact with staff, RCTP/SHU placement has occurred. He denies any suicidal ideations, plan, or intent.
  B. Copes by playing solitaire and doing crossword puzzles.
  C. Pt is compliant with medication, but continues to report they are ineffective in addressing his reported symptoms."
- Medication Compliance: "Yes"
- Mental Status/Clinical Observation:
  "Appearance: Pt presented with adequate grooming and hygiene. He was neatly dressed in weather appropriate state issued clothing. Some psychomotor agitation was observed during session. Pt would continually move his legs up and down. Adequate attention and concentration exhibited. Pt maintained eye contact.
  Speech: Speech was at normal rate, rhythm and tone. There was no increase

in volume. No pressured speech or flight of ideas.
Thought Process: Clear, logical, organized, and goal directed
Mood: Mood 'I still feel terrible.'
Affect: Affect appeared constricted and irritable.
Insight/Judgment: Insight and judgment appear functional for this environment.
Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No overt psychosis noted in session, no delusional content expressed.
Other Observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. Pt continues to report issues with sleep and motivation. No issues reported in relation to his appetite. He didn't appear tired or underweight. He appeared jittery"

- Suicide Risk Assessment:
  A) Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA? "No new risk/protective factors."
  B) Describe suicide warning signs/triggers which are present or indicate none present: "There is no evidence of any warning signs of acute risk in patient's behavior or affect. Pt reported anxiety, mood change. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts."
  If present, describe the effect on patient's functioning & plan to address: "He does not present with evidence of or symptoms suggestive of suicidal ideation at this time."
- Follow-Up/Plan: "Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled."

- **10/16/2018 Psychiatric Progress Note**
  - MED 15 Diagnoses: Mental Health: "Adjustment Disorder with Mixed Anxiety and Depressed Mood; ETOH and Cannabis Use (severe) and Opioid Use Disorder (Mod)"
    Physical Health: "No acute issues"
  - Chief Complaint and Current Issues: "'I just need medicine to help me.' Education provided to the pt and discussion regarding primary treatment (w/skill building). -last documented substance use 1st week of August."
    *Earliest release: Reports a board in January"
  - Changes in Medical Status: "No acute changes/concerns"
  - Mental Status Examination and Changes: "Pt presented as polite appearing to have difficulty accepting his role in treatment- decision making. – eye contact. Dressed neatly and good grooming and hygiene. + appetite Chronic poor sleep per pt. Speech normal rate and tone. Thought process/content reality based. No delusional content. Pt reports chronic anxiety with period of low mood. No reported or observed S/S of agitation, mania, or psychosis. Denies SI/HI. Or any thoughts of self-harm."
  - Assessment of Suicide Risk: "No acute risk of suicide"
  - Assessment/Current Diagnostic Impression/Plan: "Discussed in detail with patient the expectation he participates in treatment. Pt will be placed in group therapy to assist with skill building. Trial AM Prozac as previously offered by MD for anxiety. Continue to monitor. It appears at this time pt's primary dysfunction is his continued substance abuse."
  - Psychiatric Medications: "Prozac 20 mg po am; Trazodone 50 mg po pm for

anxiety"
- Medical Medications: "None."
- Medication Education Provided (check when provided): checked- "as well as risk of co-occurring substance use, pt verbalized understanding and denies recent substance use."
- Additional Information: (blank)
- Follow up: "45days or as otherwise clinically indicated"

- **10/26/2018 Primary Therapist Progress Note**
  - Focus of Session: "Callout was cancelled by staff and will be rescheduled within two weeks or sooner if clinically indicated as per policy."
- **11/2/2018 Primary Therapist Progress Note**
  - Focus of Session: "Pt was seen by this writer for his monthly callout. He arrived on time and was observed sitting calmly in waiting room with several peers when this writer approaches the reception area. Mr. King described his moods as 'I feel edgy; and worried.' He has been refusing medication, stating that Paxil 'makes me feel weird.' Pt informed writer that he was told by OMH nursing that his night medication both may be discontinued if he continues to refuse them. 'I find myself waiting around all day until I can get that Trazodone. They can't do that. I need it. that [sic] is the only time I feel relatively alright.' Pt continues to deny experiencing any psychotic symptoms or wanting to harm himself. 'I'll never do THAT again.' Mr. King shared with writer that he has been going to church, attending AA meetings, and going to the yard. He noted that he continues to maintain contact with his wife, his children, and his sister who are supportive of him. Pt continues to express frustration with is inability to deal with his reported 'edginess, nerve problem.' He noted that he has been working as a porter, and is waiting got return to ASAT. Writer encouraged him to speak to his prescriber about any concerns he has regarding medication. He was reminded of the importance of utilizing appropriate supports to maintain his sobriety and cope with his circumstances. No further issues or concerns were reported in relation to his MH. Pt was reminded of how to reach out to MH in case of an emergency."
  - Progress toward treatment plan goal(s)/objective(s):
    "A. Patient attended and participated in session. No overt symptoms of depression or anxiety was observed although pt reported both. Pt does not appear anxious or depressed. He denies any suicidal ideations, plan, or intent.
    B. Copes by going to church, AA meetings, and to the yard.
    C. Pt has been refusing medication."
  - Medication Compliance: "No"
  - Mental Status/Clinical Observation:
    "Appearance: Pt presented with adequate grooming and hygiene. He was neatly dressed in weather appropriate state issued clothing. No psychomotor agitation or retardation noted. Adequate attention and concentration exhibited. Pt maintained eye contact.
    Speech: Speech was at normal rate, rhythm and tone. There was no increase in volume. No pressured speech or flight of ideas.
    Thought Process: Clear, logical, organized, and goal directed
    Mood: Mood 'edgy; worried.'
    Affect: Affect appeared constricted and irritable.
    Insight/Judgment: Insight and judgment appear functional for this

environment.
Psychotic Symptoms: He denies any hallucinations and does not appear internally preoccupied. No issues reported in relation to his appetite or sleep and didn't appear tired or underweight.
Other Observations: Alert and oriented x3. Impulse and behavioral control appear intact throughout session. No issues reported in relation to his appetite. He didn't appear tired or underweight. He appeared jittery"

- Suicide Risk Assessment:
  A) Are there any changes in acute or chronic risk factors or protective factors noted on the CSRA? "No new risk/protective factors."
  B) Describe suicide warning signs/triggers which are present or indicate none present: "There is no evidence of any warning signs of acute risk in patient's behavior or affect. There were no signs of anger, anxiety, withdrawal, mood change, purposelessness, hopelessness, recklessness or feelings of being trapped. Patient's risk for suicide will be assessed on an ongoing basis. Patient denied suicidal ideation or thoughts."
  If present, describe the effect on patient's functioning & plan to address: "He does not present with evidence of or symptoms suggestive of suicidal ideation at this time."
- Follow-Up/Plan: "Primary therapist will continue to meet with patient monthly, or as needed. Prescriber will continue to meet with patient every 3 months, or as scheduled."

- **11/16/18 at 2:50 am patient was pronounced deceased**

i. A list of any statements taken from individuals interviewed in the case. (This may be noted, for convenience, on the list identified in II.C.2. above). See II C above.

ii. A list of any other documents collected in this case.

Incident Report	Attachment 1
FPMS	Attachment 2
DOCCS Unusual Incident Report	Attachment 3
Pertinent parts of UCR	Attachment 4
Emails	Attachment 5
C-Net information	Attachment 6
High Alert Form	Attachment 7
Inmate Interviews	Attachment 8
Statement Jami Palladino	Attachment 9
Statement Carrie Citrin	Attachment 10
Statement Karen Thomas	Attachment 11
Autopsy/Toxicology Report	Attachment 12

iii. **The manner in which any business records, which were collected, were secured prior to and after their collection**: Pertinent parts of the outpatient record were reviewed at CNYPC.

IV. FINDINGS

A. A list of the questions that the investigator must answer:

Were the treatment providers familiar with the patient's history?

Treatment providers were familiar with Mr. King's history as evidenced by their progress notes and the information provided in the Risk Management interviews.

Is there documentation of a recent psychiatric assessment of the patient's suicidal risk?
The most recent documented psychiatric assessment was on 10/16/2018. The treating prescriber reported "No acute risk of suicide".

How often was suicide risk assessed?
Mr. King was assessed on a regular basis during the six months preceding his death.

What recent changes had occurred in the patient's life?
Over the last six months, Mr. King consistently reported that he was depressed and anxious. However, there were not any overt symptoms of depression or anxiety observed during the sessions. His mother passed away in May of 2018; per the clinical documentation, it was reported that Mr. King was managing his grief appropriately as he had a very good support system (wife, children, sisters). However, according to patient interviews conducted with his peers post-mortem, it was noted that Mr. King had a telephone conversation with his wife around the time of his suicide and it was noted that Mr. King feared his wife was going to leave him. This information was not reported to mental health prior to the patient's death.

What changes were noted in the patient's behaviors or attitudes?
The clinical record indicated that Mr. King was using substances (Suboxone) periodically from May 2018 until September 2018. During that time, Mr. King was prescribed psychotropic medications to help manage the depression and anxiety symptoms he reported. The psychiatric and clinical team continued to provide medication education and voiced their concerns about how it was difficult to treat Mr. King's reported symptomatic complaints with psychotropic medications if he continued his substance use. Mr. King consistently wanted medication changes as he felt the psychotropic medications he was prescribed were ineffective

Are there any systems issues that may have contributed to this incident?
No systems issues noted.

INMATE/PATIENT INTERVIEWS (Conducted by Jami Palladino, Social Worker II, Lauren Curtacci, Social Worker II, Debra Betti, Social Worker II, Todd Pauley, Social Worker II, Molly Rullison, Social Worker II on November 16, 2018. The results of pertinent interviews are provided below)

Interview: [redacted]

"Patient was seen today as an unscheduled callout with this writer to assess pt.'s functioning following the suicide of a peer in the dorm as per his request. He was observed sitting in the waiting area patiently. Mr. [redacted] described his mood as 'not good'. Pt informed writer that he has a discussion with this peer yesterday about his wife being on the verge of leaving him. He stated that his individual told him 'I can't do this anymore.' 'I thought he meant this bid; couldn't do this program again. He was in the program and was kicked out an was brought back'. Pt stated that he witnessed '4 or 5' failed suicide attempts wile in county jail.' Mr. [redacted] noted that he was concerned because he felt that there should be posters in the dorm about warning signs of suicide risk. 'I know there are certain things to look for when you think someone may be thinking about suicide like giving away their things. There are posters for no smoking and sex abuse, but nothing about suicide. Maybe I could have seen something that would have let me know. I would have gone to the CO; matter of fact, didn't he attempt suicide before? Why didn't y'all

put him in the crisis unit or in the hospital where you could have kept him safe?' Writer explained that a person can't be kept in a crisis unit or hospital unless it is clinically warranted. Writer noted that sometimes people don't tell others that they are contemplating ending their lives, and that circumstances are different. Mr. [redacted] asked writer if it was normal to feel like he could have done something else. Writer pointed out this literally just happened, and it may take some time to resolve itself. However, he was reminded how to reach out should he require additional support prior to next session. Writer provided pt with grounding techniques, relaxation techniques, and with worksheets on coping with loss. Not further issues or concerns were reported in relation to his MH. Writer explained how he could reach out should he require additional services prior to next session."

Interview: [redacted]

"Pt was seen by this writer for his monthly session. He arrived on time and was observed sitting calmly in waiting room with several peers when this writer approaches the reception area. Mr. [redacted] describes his mood as 'okay'. He then stated 'the guy on my dorm hung himself'. This was processed with him and he vented his thoughts and feelings about this, stating 'it's just surprising' and 'he was having problems with his wife'. Patient further stated that he is just going to 'stay focused' and continue 'praying'. He continues to endorse maintaining compliance with his medication. Pt denied experiencing any psychotic symptoms or wanting to harm himself. He shared with writer that he has been coping with his incarceration by reading and talking to others. No further issues or concerns were reported in regards to his MH. Writer explained how he could reach out should he require additional services prior to next session."

Interview: [redacted]

"Patient was seen today as an unscheduled callout with this writer to assess pt's functioning following the suicide of a peer in the dorms as per his request. He was observed sitting in the waiting area patiently. Mr. [redacted] described himself as 'up and down. It's a lot to take in.' He informed writer that he works in the dorm as the person who orientates people to the program, and 'I'm probably someone he talks to most. I feel like I failed him be not doing something more to help.' Writer pointed out that sometimes just talking to someone and showing kindness and compassion may have already helped without him knowing. Mr. [redacted] expressed frustration with his peers in relation to how they handled the news of the passing of one of the peers in the dorm. 'They complained about being held up. They have no regard for anyone else. Is this what the world is coming to?' Pt shared with writer that he was hoping to help his peer decrease his negativity and improve his home. 'He told me he couldn't do this anymore. I figured he meant the bid; the program, being in prison. I didn't know that he meant life. He confided in me that his wife was going to leave him. I tried to give him words of encouragement, and I ended the conversation asking to borrow mayonnaise. I didn't need mayo. I wanted to distract him from his own negativity. I feel like I could have done more. I could have done or said something. I'm going home in a few months; I made my board, Ms. P. Mr. [redacted] noted that he heard something on the radio that interested him. 'I heard about the new trend, Notes of Love; people put laminated notes on bridges where people are known to commit suicide, to let them know that they are worth it. This is a sign. I'm going to do that when I go home. Bring it to the east side; it started in Oregon. I want people to know they matter. Everyone matters'. Mr. [redacted] noted that he continues to maintain contact with his family who are supportive. He identified several coping skills he uses to cope with his incarceration. Pt thanked writer for meeting with him to process this incident. Writer pointed out that sometimes things happen that make us grateful for things that we overlook, and thank our higher power that those issues aren't ours, and that is okay. At the end of the day, we as huma [sic] No further issues or concerns were reported in regards to his MH. Writer explained how he could reach out should he require additional services prior to next session."

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Interview: [redacted]

"Mr. [redacted] was seen for callout today due to requesting to speak to mental health following a recent suicide on the dorm. Mr. [redacted] presented to session and he stated 'I identified with that guy' and he elaborated by stating 'he had marital problems' and 'I have been through that too'. Patient then went on a tangent about his crime and other various topics. Writer redirected him and inquired about coping skills that he can use during this time of stress and he stated 'I clean, it helps me feel better.' He also stated that he listens to classical music and that he believes in a higher power. Additionally, he was future oriented on his release in the next couple of years and he expressed that he 'wants to keep work on himself'. He continues to use session to vent and process his feels[sic] about the noted circumstances and various other circumstances as they came to his mind. Mr. [redacted] denied current suicidal ideation, intent, or plan and he stated 'I will be okay'."

Interview: [redacted]

"Pt asked to be seen today because a guy on his dorm committed suicide last night. Pt says that he knew the guy for about a week. He said the guy would laugh and joke all day until he got on the phone and then he would be crying while on the phone. He says it triggered memories of finding his friend hanging 5 years ago. The friend was dead. He coped by using drugs. He wants to cope with things and stay sober. SW encouraged him to find time to fully feel his feelings-his sadness, so that it can pass through him. He agreed. SW encouraged Pt to read the Greif packet that he was given. Pt is looking forward to release. He had excellent support. He discussed his sobriety. He denies any SI/HI."

Interview: [redacted]

"Patient was seen by this writer due to requesting to speak with mental health after someone committed suicide on his housing unit. This writer questioned patient about how he has been managing the recent death. He shared with this writer that the recent death reminded him of when he was 14 years old and 'a girl I knew shot herself.' This writer questioned the connection to the current situation. He shrugged and began talking about how the girl was abused and he related to her and is now focusing on his abuse history. This writer explained to patient that in each session, he wants to focus on his trauma history, however, is not receptive to change. This writer asked patient if he knew the person that committed suicide. He reported the person was his Bunkie, however, they did not interact or speak to each other. Patient discussed feeling 'frustrated' as he was not able to prevent the event form occurring. This writer and patient discussed different stages of grief and the importance of recognizing that no one was to blame for the event. Patient then tried to discuss his trauma history. This writer redirected and explained to patient that he was being seen today to discuss the suicided that occurred. Patient nodded and denied any current thoughts of self-harm. He stated 'I've tried before, it never works, so I kinda gave up on trying'. This writer stressed to patient the seriousness of suicide and suicide attempts. He appeared indifferent. Patient did not appear in any emotional distress about the event. He denied any symptoms related to depression or anxiety. He did not want any reading materials on grief and loss and stated 'I'll be okay. I'm stubborn'. This writer made patient aware how to reach MH if needed. He again denied any thoughts of self-harm."

Interview: [redacted]

"Patient reported his mood as 'not good'. He shared with this writer that last night someone on his housing unit committed suicide. He identified this person as his friend and reported feeling confused about why it happened. He engaged in conversation about the recent death and was given adequate time to process his thoughts and emotions. He was offered a grief and loss packed, however, denied a need to

complete. He shared with this writer that he was managing 'just fine'. He reported that this event 'gives me more motivation to get home'."

Interview: [redacted]

"Pt was called down because one of his roommates committed suicide last night. Pt says he was asleep and he heard the news in the morning. He says the victim had been saying "she's gonna leave me' recently-talking about his wife. He says he tried to encourage him. He says the victim would occasionally state 'I don't want to live', and the Pt would encourage him to look at the positives. Pt feels bad for this victim but is coping effectively. He is focused on completing program and going home within the next 2 months."

OMH EMPLOYEE INTERVIEWS

Interview: Jami Palladino, Mid-State Correctional Facility Social Worker II – January 8, 2019 at 11:54 AM

"I am a Social Worker II at Mid-State Correctional Facility. I have been working here for 5 years. I have been a General Population (GP) clinician for those 5 years. As of December 3, 2018, I transitioned into the Pre-Release Coordinator Role. My current job responsibilities are providing discharge planning services for the Mental Health Service Level (MHSL) 1, 1S, and 2S OMH patients at Mid-State Correctional Facility. As needed, I cover some of the GP assignments such as VTC and emergency coverage. I also work overtime completing Utilization Reviews to assist with closing cases, record requests for community records, S designation paperwork, and occasionally I will write up additional discharge summaries.

During my role as a GP clinician, my job responsibilities included providing individual/group therapy sessions for approximately 180 mental health patients. I provided group therapy for the individuals that were on my caseloads that were a MHSL 3 and 4. I completed parole evaluations, discharge planning for my patients who MHSL's were 2, 3, and 4. I facilitated VTC 1 day a week (originally it started off at 3 times a week), requested community records, and writing S designations.

I was the GP clinician assigned to Joseph King. I worked with Mr. King the entire time he was here. I believe the duration was 3 years. He attended his sessions every month. He appeared to have some adjustment issues with prison. We tried to provide as much encouragement for him to make other choices or change his perception in terms of how he viewed prison and being away from his family. He always expressed that he was anxious and depressed about being incarcerated. He did not exhibit outwardly anxiety symptoms. He was provided with coping skills worksheets on anxiety, depression, distress intolerance, and social anxiety. He would take the worksheets at times and then refused as he did not find them helpful. After his first suicide attempt [2016] his medications were discontinued to help assess the need for further medications due to his substance use. Over the past six months to a year, Mr. King was hyper focused on medications and substance use. He minimized his substance use (per self-report he was using Suboxone) and wanted mental health medications to help with his self-report of anxiety and depression. Again, he did not present with signs or symptoms of anxiety. I reinforced him to build alternative coping skills in conjunction with medication. Based on his self- report, he presented as adequately groomed and no changes in affect. His affect was incongruent to what he was reporting. For a while he stopped going to church and AA/NA meetings, but then restarted. His mother passed away in April or May. I was concerned about this loss and made a point to process this with him. However, he was sad about the loss of his mother but did not identify it as a trigger for his depression. He had a good support network. He had his wife, 2 children, sisters, and brothers as a positive support.

He consistently denied thoughts of self-harm, suicidal ideations. During his session, he did present with any functional impairment that would require a higher level of care.

In May of 2018, Mr. King wanted medication changes because it was not working. He was reported difficulty in sleeping and wanting an increase in his Trazodone. At that time the prescriber was adjusting and titrating the medications. In June medications were discontinued. In regards to the progress note dated July 23, 2018, stating that he was compliant with medications I intended to write that the medications were restarted not meaning compliant with them.

On November 2, 2018 at 10:00 AM I did meet with Mr. King and wrote a progress note. The progress note was never added to the chart. He was refusing medications Paxil and wanted an increase in Trazodone. He self- reported that he was frustrated and edgy. I encouraged him to reach out to his prescriber regards to his medications. I continued to encourage him to use alternative coping skills. No overt symptoms of depression or anxiety observed despite him reporting it. Affect appeared constricted but incongruent with reported mood. He denied suicide plan, intent. I recall him stating "I will never do that again".

Interview: Carrie Citrin, Mid-State Correctional Facility Psychiatric Nurse Practitioner – January 15, 2019 at 9:10 AM

"I have been working for Central for almost 9 years as a Registered Nurse. I have been working in this title (Psychiatric Nurse Practitioner) for approximately 4 years I have been at Mid-State, working in the capacity of a Nurse Practitioner for the past three years. My current job responsibilities at Mid-State CF are that I am assigned a patient's case load, assessment and medication management, I also handle unit tasks and unit concerns. In the absence of a VTC psychiatrist or other on-site prescribers I would cover those services when needed as well.

I had one meeting with Mr. King, his case was recently transferred to me from VTC Dr. Thomas. I reviewed his OMH level and discussed medications and current plans for treatment. We discussed his substance use and history of suicide attempts. At that time, he was relatively stable and future oriented. He had a lot of chronic risk factors including his substance abuse but no evidence of current acute risk factors. Prozac was offered previously by Dr. Thomas and for the purpose of continuity of care and Mr. King's current complaints of anxiety and periods of low mood I initiated Prozac in morning as a trial in conjunction with verbal therapy. We discussed his triggers for SI and past attempts and at the time of the interview he had no thoughts or report of suicidal ideation, plan or intent.

Typically, in my first meeting with a patient, I review the diagnosis, but it is uncommon for a change to be made at that time. There was no major concern with the current diagnosis. As we continued to build rapport in future callouts assessment and diagnostic clarification would be ongoing."

Interview: Karen Thomas, Mid-State Correctional Facility- Psychiatrist II- February 27, 2019 at 1:10 PM

"I have been working for CNYPC for 5 ½ years. I am employed as a psychiatrist and I originally began working at the Bronx VTC suite where I provided telepsychiatry services to 5 different facilities. When I was at switched Manhattan VTC, I then began working with Mid-State Correctional Facility. I am currently still providing telepsychiatry services but I'm located at Pilgrim VTC Suite. My assignments changed in January 2018, at that time I was assigned to Mid-State on Mondays and Wednesdays and assigned to Auburn on Tuesdays and Thursdays. I work a four day week from 7am to 5pm. My job responsibilities include evaluating and treating patients by doing initial psychiatric evaluations and

medication follow-ups. On Thursdays, I also treat patients who are placed in the RCTP-Observation unit at Auburn CF.

Mostly from my notes, I remember Mr. King reported feeling really depressed, anxious and struggling with substance use. He also reported that his medications were not helping him. I was trying to treat his anxiety, his depression and have him stop using suboxone. When he came to me in May of 2018, he was already on medications. He was being treated for anxiety and depression. He also reported that he recently lost his mother. He reported to me that his depression and anxiety symptoms were problematic prior to the loss of his mother and wanted his medications changed. I then increased his Celexa and Vistaril. Since he was not doing well, I did ask for him to come back in 4-6 weeks. When I saw him in June of 2018 he was feeling the same; depressed, tired and unmotivated. He also admitted to using Suboxone and stated his meds were not helping. Celexa was at the maximum dose. I then tapered and discontinued the medications and offered to give him a trial of Prozac but he declined. I asked that he come back in two months. I actually saw him a month later in July of 2018. He reported a lot of anxiety, panic attacks and feeling more depressed. Basically, he described feeling worse. He denied suicidal thoughts each time I saw him and reported to have support from his wife and children. I started him on Zoloft and Trazodone to address the depression, anxiety, and sleep difficulties. Mr. King requested to be placed on Trazodone as he reported he did well on it in the past. I asked for him to return in 4-6 weeks because I started him on a new medication and he was not doing well. I saw him again in August of 2018 and again he reported not doing well. He complained of anxiety and depression and continued to admit that he was using Suboxone since he was last seen. At that session, he reported some improvement with his sleep as well as having continued contact with his wife and children. I did counsel him on the use of Suboxone and educated him that the Suboxone could be causing side effects and withdrawal symptoms, which could have contributed to the anxiety and depression that he was describing. I encouraged him to attend NA/AA and work on the anxiety packet that his therapist gave him. I left his meds the same. I asked him to come back in two months.

The typical follow-up for a general population patient with his diagnosis is usually three months. Patients who are seen every three months usually are stable and doing well. If they are not doing well, I ask them to come back earlier. I was seeing him sooner because he was not doing well. I did not consider him to be in need for RCTP because I was having him scheduled with an earlier follow-up appointment. He was having symptoms of depression and anxiety and continued to deny having suicidal thoughts. He was goal directed for treatment, he had a good support system with his wife, children, and sister. He did not have much time left in his bid. He knew how to contact mental health if there was an emergency situation or if his symptoms worsened. At the end of each visit, I tell my patients when they will be seen again and I let them know if there is an emergency they can let their officer know or they can write to mental health if they need to be seen sooner.

Most of the time, I use the NEMONIC-IS PATH WARM, I could have done a better job with documenting his anxiety and active substance use in the assessment of suicide risk. I review the CSRA at the initial meeting and review the content with the patient at that time. I should review and consider making changes to the patient's diagnosis at each visit. Mr. King did have significant symptoms of depression and anxiety and I should have considered MDD as rule out diagnosis and explored adding on Opioid Use Disorder. Since MDD is an SMI diagnosis I usually am not quick to change it to an SMI diagnosis unless the patient has a history that supports it. I would have explored this further had I seen him again and he continued to still have significant symptoms."

V. **CONCLUSION:** (Include an answer to each question identified in "Summary of Evidence" and any reasons for your conclusion.)

Risk Management staff found the mental health care provided to Mr. King was adequate in terms of the treatment goals identified and risk assessments conducted. There were some issues noted with the case, as described below. It appears that these issues did not contribute directly to the outcome of this case

ISSUE: The Chronological Record was not properly filled out when Mr. King was discharged from CNYPC. The Chronological Record discharge date from CNYPC was omitted from record. The last entry was "8/4/16, PRG from RCTP dorm to MSCF GP-1S".

RECOMMENDATION: Mid-State CF Unit Chief to review Policy #9.7 Chronological Record with all staff involved.

ISSUE: The Primary Therapist Progress Note, dated 7/23/2018, Medication Compliance section was marked "Yes" indicating that Mr. King was compliant with medications. Mr. King was not prescribed with psychotropic medications at that time. His medications were discontinued by his treating psychiatrist on 6/25/2018.

RECOMMENDATION: Mid-State CF Unit Chief will review Policy # 9.30 Progress Notes with staff involved and review the importance of ensuring that all documentation is accurate.

ISSUE: The Primary Therapist Progress Notes suicide risk assessment sections dated 6/25/2018, 7/23/2018, 9/27/2018, and 11/2/2018 read "No warning signs present" when the focus of the sessions notes Mr. King reported symptoms of depression, anxiety, sleep difficulties, recent hospital visit (June-medically related), and substance use. The section "Are there any changes in acute or chronic risk factors noted on the CSRA" should have checked "Yes" and noted the changes in the risk and protective factors. Additionally, section B should have listed the warning signs/triggers that were present and noted in the "Focus of Session" section of the document. The recent loss of his mother and his Suboxone use should have been listed in section B in every progress note completed from May through last contact.

In addition, the Psychiatric Progress Notes assessment of suicide risk section dated 6/25/2018, 7/23/2018, 8/27/18 read "No warning signs present". The documentation notes warning signs/risk factors of increased substance use, continued/increased depression/anxiety, loss of his mother in May 2018, and sleep disturbance.

RECOMMENDATION: Mid-State CF Unit Chief will review Policy # 1.0 Comprehensive Suicide Risk Assessment Process, specifically (but not limited to) part D Progress Notes with staff involved.

ISSUE: Mr. King's assigned clinician at Mid-State CF indicated she met with Mr. King on 11/2/2018 for a scheduled session; however, there was no corresponding progress note for this contact in the chart at the time of death. The progress note was reportedly completed, by had not been filed in the clinical record prior to the patient's death and was later provided to Risk Management, and mailed to the inpatient HIM department, on 1/15/2019.

RECOMMENDATION: Mid-State Unit Chief to review with staff involved the importance of ensuring all progress notes are submitted for timely entry in the case record.

ISSUE: A Comprehensive Suicide Risk Assessment was created on 9/9/2013 and updated on 9/8/2015, 8/4/2016, and 8/27/2018. Per Policy #9.16 Comprehensive Suicide Risk Assessment Form as it pertains to time frames, a CSRA should be completed as clinically indicated. More specifically, a CSRA update should be completed when a significant change occurs relevant to suicide risk. Mr. King's mother passed away in May of 2018 and he began using Suboxone around that time. Both of these events should have been identified as significant risk factors for suicide and the CSRA should have been updated in May of 2018; however, the CSRA was not updated until 8/27/2018. While the 8/27/2018 CSRA has "substance abuse/dependence history" checked on the front of the form, Mr. King's recent return to Suboxone use was not mentioned in the narrative description. Additionally, the narrative section of the 8/27/2018 CSRA did not address the fact that Mr. King's protective factors changed after the loss of his mother and his

strained relationship with his wife, both of which were mentioned in the 8/27/2018 primary therapist progress note. Although the 8/27/2018 CSRA does mention Mr. King's mother passed, it incorrectly notes that she passed in June 2018, rather than May 2018.

RECOMMENDATION: Mid-State CF Unit Chief will review Policy #9.16 Comprehensive Suicide Risk Assessment Form with staff involved

JENNETTE BRADY, LCSW
CBO RISK MANAGEMENT SPECIALIST

DATE COMPLETED 6-6-19

MAUREEN MORRISON, LCSW
CBO DIRECTOR OF RISK MANAGEMENT